Hawaii Employer-Union
Health Benefits Trust Fund

IMPORTANT DOCUMENT

This COBRA GENERAL NOTICE contains important information and instructions regarding your health benefits continuation coverage under COBRA.

When and if your health benefits coverage is terminated, this document becomes extremely important for you to protect your rights under COBRA

The American Recovery and Reinvestment Act of 2009 provides additional benefits for certain qualified beneficiaries by providing COBRA premium assistance. Review this document carefully.

If you fail to comply with these instructions, you may lose your eligibility for COBRA continuation of coverage.

PLEASE KEEP THIS PAMPHLET WITH YOUR IMPORTANT PAPERS

IMPORTANT DOCUMENT

GENERAL NOTICE
CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage under the Plan would normally cease. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA and the description of COBRA continuation coverage set forth in this notice applies only to the group health plan benefits offered under the Plan (the group health care components are identified above) and does not apply to any other benefits offered under the Plan or by the EUTF such as life insurance, disability insurance, or accidental death and dismemberment benefits.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you in certain circumstances when you would otherwise lose your group health coverage under the Plan. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA continuation coverage rights or other rights you may have under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA Notice on the Plan's website at www.eutf.hawaii.gov or contact the EUTF for a hard copy. The Plan provides no greater COBRA continuation coverage rights than what COBRA requires, and nothing in this notice should be understood to expand your rights beyond what COBRA requires.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

What Is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event occurs and any required notice of that event is provided to the EUTF, COBRA continuation coverage must be offered to each person who loses or will lose coverage under the Plan who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries and would be entitled to elect COBRA continuation coverage if coverage under the Plan is lost because of the Qualifying Event.

Also, if a child is born to you or adopted by or placed for adoption with you during a period of COBRA continuation coverage, or if you are required to provide coverage to a child under the terms of a Qualified Medical Child Support Order (QMCSO), that child may become a Qualified Beneficiary. This is discussed in greater detail later in this notice. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Who Is Entitled to Elect COBRA Continuation Coverage?
If you are an employee, you will become a Qualified Beneficiary and entitled to elect COBRA continuation coverage if you lose your group health coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary and entitled to elect COBRA continuation coverage if you lose your group health coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

    If an employee cancels coverage for the spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered the Qualifying Event, even though the ex-spouse lost coverage under the Plan before the occurrence of the divorce or legal separation. If the ex-spouse notifies the EUTF within 60 days after the divorce or legal separation and can establish that the employee earlier cancelled the spouse's coverage under the Plan in anticipation of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

Your dependent children who are enrolled in the Plan will become Qualified Beneficiaries and entitled to elect COBRA continuation coverage if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

The "Gross Misconduct" Exception

If a covered employee is terminated for "gross misconduct," then no Qualifying Event has occurred with respect both to the covered employee and any covered dependents (spouse and/or children). Neither the covered employee nor the covered spouse or any covered dependent

children are entitled to elect COBRA in this circumstance. However, the COBRA statute and associated regulations contain no definition of "gross misconduct," and the legislative history of the statute makes clear that "gross misconduct" is not the same as "for cause." In addition, courts have not consistently decided whether "gross misconduct" is limited to conduct at the workplace, or that "gross misconduct" must occur within the scope of employment. The employer should seek appropriate legal counsel from the deputy Attorney General assigned to the employer before declaring an employee terminated due to the "gross misconduct."

How much does COBRA continuation coverage cost?
Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is shown on the enclosed COBRA rates for each of the health benefit plan. To determine the cost of your plan under normal circumstances, check the premium cost for under the Self, 2-Party or Family columns to determine what your premiums will be for each plan.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When Is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the EUTF has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment or the death of the employee, your employer must notify the EUTF of the Qualifying Event. The employee will not need to notify the EUTF of the occurrence of any of these three Qualifying Events.

You Must Give Notice of Some Qualifying Events
For the other initial Qualifying Events (e.g., divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the EUTF with notice of the Qualifying Event within 60 days after 1) the date of the Qualifying Event or 2) the date of the loss of coverage under the Plan.

You must provide this notice in writing by appropriately completing the attached "Notice of a COBRA-Related Event." You must follow the procedures specified below in the section entitled "Notice Procedures" and you must return the signed and dated form along with appropriate supporting documentation of the initial Qualifying Event within the time period described above. The section entitled "Notice Procedures" also describes what the Plan will accept as appropriate

supporting documentation of the initial Qualifying Event. Oral notice, including notice by telephone, is not acceptable, and electronic notice by e-mail is not acceptable. You may return the "Notice of a COBRA Related Event" to the EUTF by mail, by fax or by hand-delivery according to the procedures specified below in the section entitled "Notice Procedures." **If you do not follow these procedures or if you fail to provide written notice to the EUTF within the 60-day notice period, YOU AND ANY OTHER FAMILY MEMBERS WHO WOULD OTHERWISE BE QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHTS UNDER COBRA, INCLUDING THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE.**

How Is COBRA Coverage Provided?
Once the EUTF receives timely notice that an initial Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their covered spouses, and parents may elect COBRA continuation coverage on behalf of their covered children. For each Qualified Beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the later of the date of the Qualifying Event or the date of the loss of group health coverage under the Plan.

If you or your spouse or your dependent children do not elect COBRA continuation coverage within the 60-day election period which begins as of the date of the COBRA Election Notice provided by the EUTF, YOU WILL LOSE YOUR RIGHTS UNDER COBRA TO ELECT CONTINUATION COVERAGE.

Qualified Beneficiaries may be enrolled in one or more group health care components of the Plan at the time a Qualifying Event occurs. If a Qualified Beneficiary is entitled to elect COBRA continuation coverage as a result of the Qualifying Event, he or she may elect COBRA continuation coverage under any or all of the group health care components of the Plan under which he or she was covered on the day before the occurrence of the Qualifying Event. For example, if a Qualified Beneficiary was covered under the medical and dental components of the Plan on the day before the Qualifying Event occurred, he or she may elect COBRA continuation coverage under the medical component only, the dental component only, or under both the medical and dental components. However, if the Qualified Beneficiary were not covered under the dental component of the Plan on the day before the Qualifying Event occurred, then the Qualified Beneficiary would not be entitled to elect COBRA continuation coverage under the dental component of the Plan.

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if, on or before the day they elect COBRA continuation coverage, they have other group health plan coverage or are entitled to benefits under Medicare (under Part A, Part B or both). However, a Qualified Beneficiary's COBRA continuation coverage will automatically end if, after electing COBRA continuation coverage, he or she becomes covered under another group health plan or becomes entitled to benefits under Medicare (under Part A, part B or both), provided only that any applicable preexisting condition exclusion of the other group health plan has been exhausted or satisfied.

How Long Does COBRA Continuation Coverage Last?
COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for only up to a total of 18 months. The COBRA continuation coverage periods described above are maximum coverage periods. COBRA coverage can end before the maximum coverage period described in this Notice for several reasons.

There are three ways in which this 18-month period of COBRA continuation coverage resulting from a reduction in hours or employment or termination of employment can be extended.

Disability extension of 18-month period of continuation coverage
If a Qualified Beneficiary in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the EUTF in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum COBRA coverage period of 29 months. This extension of the COBRA coverage period is available only for Qualified Beneficiaries who are receiving COBRA continuation coverage because of a Qualifying Event that was the covered employee's reduction in hours of employment or termination of employment. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours of employment and must last at least until the end of the 18-month period of continuation coverage resulting from the initial Qualifying Event.

The additional 11 months of COBRA continuation coverage will be available as long as the disabled individual continues to be disabled. However, if the Social Security Administration subsequently makes a final determination that the disabled individual is no longer disabled, and the cessation of disability occurs before then end of the 11th month of additional coverage, the EUTF will terminate the COBRA continuation coverage for all Qualified Beneficiaries as of the first day of the month that is more than 30 days after the date of cessation.
You must provide the EUTF with notice of the Social Security Administration's disability determination within 60 days after the latest of:

The date of the Social Security Administration's disability determination;

The date of the covered employee's termination of employment or reduction in hours of employment; or

The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in hours of employment.

In addition, in order to be entitled to the disability extension you must provide the EUTF with notice of the Social Security Administration's disability determination within 18 months after the covered employee's termination of employment or reduction in hours of employment. If you

provide notice to the EUTF of the Social Security Administration's disability determination at a date more than 18 months after the covered employee's termination of employment or reduction in hours of employment, you will not be entitled to the disability extension, even if you provided the notice within 60 days after receiving the Social Security Administration's disability determination.

You must provide notice of the disability determination in writing by appropriately completing the attached "Notice of a COBRA-Related Event." You must follow the procedures specified below in the section entitled "Notice Procedures" and you must return the signed and dated form along with appropriate supporting documentation of the Social Security Administration's disability determination within the time period described above.

Second Qualifying Event extension of 18-month period of continuation coverage
If your family experiences another Qualifying Event while receiving 18 (or 29) months of COBRA continuation coverage resulting from the covered employee's termination of employment or reduction in hours of employment (or during the disability extension period following either of these Qualifying Events), the spouse and dependent children in your family who are receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for up to a maximum of 36 months of COBRA continuation coverage under these events:

The employee or former employee dies

Gets divorced or legally separated

If the dependent child stops being eligible under the Plan as a dependent child, but only if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

For second Qualifying Events, you must provide the EUTF with written notice of the second Qualifying Event within 60 days after the second Qualifying Event occurs.

Medicare extension for a spouse and dependent children
If a Qualifying Event that is a termination of employment or reduction of hours of employment occurs within 18 months after the covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both), then the maximum coverage period for the spouse and dependent children (but not the employee) will be up to 36 months from the date the employee became entitled to Medicare benefits. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children who lost coverage under the Plan due to the employee's termination of employment can last up to 36 months after the date of the employee's Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). However in this situation, the covered employee's maximum coverage period will be 18 months.

Children Born To or Placed for Adoption with the Covered Employee during a Period of COBRA Continuation Coverage
A child born to or adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary provided that, if the

covered employee is a Qualified Beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. The newborn or adopted child's COBRA continuation coverage begins when the child is enrolled in the Plan, whether under the special enrollment rights mandated by the Health Insurance Portability and Accountability Act (HIPAA) or during an open enrollment period, and the COBRA continuation coverage lasts as long as COBRA coverage lasts for other family members who have previously elected COBRA continuation coverage. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements of the Plan (for example, regarding attained age or student status).

Alternate Recipients under QMCSOs
A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the EUTF during the covered employee's period of employment with State or appropriate county*, is* entitled to the same rights under COBRA as an eligible dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent under the eligibility requirements of the Plan.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you must notify the EUTF of any changes in the addresses of family members by submitting a fully completed Enrollment Change Form (EC-1) to the EUTF. The EC-1 form is available from the EUTF. You should also keep a copy, for your records, of any notices or forms you send to the EUTF.

Plan Contact Information
You must mail any notices or forms described in this Notice to the EUTF at the following address:

Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089
Fax: (808) 586-2161

You may fax any notices or forms described in this Notice to the EUTF at the fax number shown above. You may hand-deliver any notices or forms to the EUTF at the EUTF's offices located at 201 Merchant Street, Suite 1520, Honolulu, HI.

If you have questions regarding this Notice or your rights under COBRA, you may call the EUTF at the telephone number shown above. You may also view the EUTF's "COBRA

Notice" on the website at: www.eutf.hawaii.gov or find additional information about COBRA in the Reference Guide for Active Employees (effective July 1, 2004).

Notice Procedures

You must provide notice to the EUTF of certain Qualifying Events and of other vents that affect the continuation or duration of your COBRA continuation coverage. These Qualifying Events and other events are described below. You must provide this notice in writing by using Enrollment Change form (EC-1) through your employer or personnel office or by completing the "Notice of a COBRA-Related Event" which follows these Notice Procedures. You must fully complete the "Notice of a COBRA-Related Event," attach any required documentation specified below, and mail, fax or hand-deliver the signed and dated Notice to the plan contact listed above.

Specifically, you must use this Notice to inform the EUTF of the following:

1. Certain initial Qualifying Events:

A divorce or legal separation of the covered employee and the covered spouse; or
A covered dependent child ceasing to be a dependent under the terms of the Plan;

2. The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA continuation coverage with a maximum COBRA coverage period of 18 or 29 months; and

3. The occurrence of the following event which may affect the continuation or duration of a Qualified Beneficiary's COBRA continuation coverage after COBRA has been elected:
The determination by the Social Security Administration that a Qualified Beneficiary who is entitled to COBRA continuation coverage with a maximum COBRA coverage period of 18 months is disabled at any time during the first 60 days of COBRA continuation coverage.

Please note that you do not need to notify EUTF of an initial Qualifying Event that is the end of employment or reduction of hours of employment or the death of the employee. Instead your employer must notify the EUTF of these three initial Qualifying Events.

The following individuals may provide the Notice of the initial Qualifying Event:

The covered employee (that is, the employee or former employee who is or was covered under the Plan);

A Qualified Beneficiary with respect to the initial Qualifying Event being reported in the Notice; or

A representative acting on behalf of the covered employee or a Qualified Beneficiary. A power of attorney or court order will be required before action is taken on any document submitted by a representative.

A Notice of an initial Qualifying Event provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage under

the Plan due to the Qualifying Event identified in the Notice.

Procedure for Giving Notice of an Initial Qualifying Event that is a Divorce, Legal Separation or Loss of Dependent Status

When the initial Qualifying Event is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child under the terms of the Plan, you must notify the EUTF in writing within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

If the initial Qualifying Event is a dependent child's loss of eligibility under the terms of the Plan, you must provide satisfactory documentation of the date of the Qualifying Event to the EUTF when requested by the EUTF. Examples of satisfactory documentation include a marriage certificate, school transcript/document, etc. Failure to submit requested documentation may result in the rejection of an incomplete notice and forfeiture of your right to elect COBRA continuation coverage.

Procedure for Giving Notice of a Second Qualifying Event Following Termination of Employment or Reduction of Hours

When you wish to give notice of a second Qualifying Event (such as the covered employee's death, a divorce or legal separation of the employee and spouse, or a dependent child's loss of eligibility under the terms of the Plan) following an initial Qualifying Event that is the end of employment or reduction of hours of employment, you must notify the EUTF in writing within 60 days after the later of (1) the date of the second Qualifying Event; or (2) the date on which the Qualified Beneficiary (that is, the covered spouse or dependent child) would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if this Qualifying Event had occurred while the Qualified Beneficiary was still covered under the Plan). You must provide notice of a second Qualifying Event by using the Plan's "Notice of a COBRA-Related Event."

If you provide the EUTF with a written notice of a second Qualifying Event that does not contain the information required by these Notice Procedures, the Plan will nevertheless consider your notice to be timely **if all of the following conditions are met:**

The notice is mailed, faxed or hand-delivered to the individual and address specified above;

The notice is provided by the deadline specified above;

From the written notice provided, the EUTF is able to determine that the notice relates to the Plan;

From the written notice provided, the EUTF is able to identify the covered employee and the Qualified Beneficiary(ies), the nature of the second Qualifying Event and the date on which the second Qualifying Event occurred; and

The notice is supplemented in writing with the additional information and/or documentation necessary to meet the Plan's requirements. If the Plan requests additional information or documentation, you must provide the additional information or

documentation within 15 business days after the EUTF's written or oral request to provide the information (or, if later, by the 60-day deadline for giving notice of a second Qualifying Event described above). If all of these conditions are met, the Plan will treat the notice of a second Qualifying Event as having been provided in a timely manner.

Procedure for Giving Notice of the Social Security Administration's (SSA) Determination of Disability

When the SSA determines that a Qualified Beneficiary is disabled and you wish to qualify for the disability extension of the 18-month COBRA coverage period, you must provide the EUTF with the "Notice of a COBRA-Related Event" within 60 days after the latest of (1) the date of the SSA's disability determination, (2) the date of the covered employee's termination of employment or reduction in hours of employment, or (3) the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction in hours of employment. In addition, you must provide the SSA's determination of disability within 18 months after the covered employee's termination of employment or reduction in hours of employment. You must provide notice of the SSA's determination of disability by using the Plan's "Notice of a COBRA-Related Event."

Procedure for Giving Notice of the SSA's Determination that a Disabled Qualified Beneficiary Is No Longer Disabled

When the SSA determines that a disabled Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must provide the EUTF with the "Notice of a COBRA-Related Event" in order to advise the Plan of the cessation of disability. You must provide this Notice within 30 days after the date of the SSA's determination that the disabled Qualified Beneficiary is no longer disabled. You must include a copy of the SSA's determination of the cessation of disability with your "Notice of a COBRA-Related Event."

If the SSA's determination of the cessation of disability is dated prior to the initial maximum COBRA coverage period of 18 months, COBRA continuation coverage for all Qualified Beneficiaries will terminate at the end of the 18th month of COBRA continuation coverage.

If the SSA's determination of the cessation of disability is dated after the initial maximum COBRA coverage period of 18 months, COBRA continuation coverage for all Qualified Beneficiaries will terminate at the first day of the full month after the date of the SSA's determination that the disabled Qualified Beneficiary is no longer disabled.

If you fail to give the EUTF timely and proper notice of the Social Security Administration's determination that the disabled Qualified Beneficiary is no longer disabled, the EUTF reserves the right to terminate COBRA continuation coverage for all Qualified Beneficiaries retroactive to the date COBRA continuation coverage would have terminated if you had given timely and proper notice of the SSA's determination that the disabled Qualified Beneficiary is no longer disabled. The EUTF also reserves the right to require repayment to the EUTF of the cost of all benefits provided or paid after the date COBRA continuation coverage would have terminated, regardless of whether or when you give notice that the disabled Qualified Beneficiary is no longer disabled.

What can I do if my former employer's group health plan denies my application for the premium reduction?
If the plan determines that you are not eligible for the premium reduction, you can request an expedited review of the denial. The Department of Labor will handle appeals related to private sector employer plans subject to ERISA's COBRA provisions. The Department of Health and Human Services will handle appeals for Federal, State, and local governmental employees, as well as appeals related to group health insurance coverage provided pursuant to state continuation coverage laws. The Departments are required to make a determination regarding your appeal within 15 business days after receiving your completed application for review.
Note: Appeals to the Department of Labor must be submitted on a U.S. Department of Labor application form. The form will soon be available at www.dol.gov/COBRA and can be completed online or mailed or faxed as indicated in the instructions. If you believe you have been inappropriately denied eligibility for the premium reduction, you may wish to speak with an Employee Benefits Security Administration Benefits Advisor at 1.866.444.3272 before filing this form.

How can I get more information on my eligibility for COBRA or the premium reduction?
Guidance and other information is available on the Department of Labor, Internal Revenue Service and Department of Health and Human Services web sites

DOL: **www.dol.gov/ebsa/cobra.html,**
DHHS: **www.cms.hhs.gov/home/regsguidance.asp,**
IRS: **www.irs.gov/pub/irs-drop/n-09-27.pdf.**

For general information regarding your plan's COBRA coverage or the administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, you can contact the EUTF at 808-586-7390; toll free 800-295-0089, via email at eutf@hawaii.gov or by mail at P.O. Box 2121, Honolulu HI 96805. You also may access the our website at www.eutf.hawaii.gov for more COBRA information.

Summary of the COBRA Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from February 17, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period. If you are currently enrolled in COBRA and you are determined to be eligible for premium reductions, your insurance carrier will either reimburse you for any over payment or credit your future payments. Please contact your insurance carriers for specific information. **NOTE: To be eligible for the premium subsidy, you must complete and submit the Request for Treatment as an Assistance Eligible Individual to the EUTF. You will be eligible for the premium subsidy only after your request is validated.**

♦ IMPORTANT ♦

◊ **If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.**

◊ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

◊ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

Hawaii Employer-Union Health Benefits Trust Fund	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

TO QUALIFY, YOU MUST BE ABLE TO CHECK "YES" FOR ALL STATEMENTS.*

1. The loss of employment was involuntary	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes	☐ No
3. I elected (or am electing) COBRA continuation coverage.*	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No

***If you checked NO for Statement 3, you may still be eligible. See below for more information**

If your COBRA continuation coverage relates to an involuntary loss of employment prior to or on December 31, 2009, and you were eligible for, but waived COBRA coverage, you still have the right to to revoke your waiver and elect to enroll in COBRA. You must, however, revoke and submit your waiver in writing within the 60-day election period. In this scenario, your COBRA start date may begin on the date your waiver is revoked and therefore, your premium subsidy will not begin until that date. You can contact the EUTF at 586-7390 or toll free at 808-295-0089 or at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813 or go to our website at www.eutf.hawaii.gov for more information.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature _____ Date_____

Type or print name:_____ Relationship to Employee:

FOR EMPLOYER VALIDATION

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual was not enrolled in a health benefit plan when terminated.	☐

4. Other (please explain)

Signature of employer:

Signature _____ Date_____

Type or print name:_____	Position Title_____
Telephone Number:_____	E-mail address:_____

To apply for ARRA Premium Reduction, complete this form and return it to the EUTF along with you COBRA Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual to the EUTF at P.O. Box 2121, Honolulu HI 96805 or you can deliver it to our office at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813.

Be sure to read the important information about your rights and responsibilities included in the "Summary of the COBRA Premium Reduction Provisions under ARRA." For more detailed information, please access our website at www.eutf.hawaii.gov.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL (continued)

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name	Date of Birth	Relationship	SSN
a.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
b.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
c.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
d.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
e.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

NOTE: If there are more dependents, please make a copy of this page and complete it for your additional dependents.

Hawaii Employer-Union Health Benefits Trust Fund	**NOTIFICATION OF INELIGIBILITY FOR COBRA PREMIUM ASSISTANCE**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION - Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below.	Enter the date you became eligible:

Enter the group health plan name: _____

If you are eligible for coverage under another group health plan and that plan covers dependents, you must also list their names here.

	_____ _____ _____ _____		_____ _____ _____ _____

I am eligible for Medicare.	Enter the date you became eligible:

IMPORTANT

The American Recovery and Reinvestment Act of 2009 limits the period of premium assistance available to involuntarily terminated employees.

1 Up to nine months maximum

2 When you become eligible to enroll in another group heal plan

3 When you become eligible for Medicare benefits

4 For high income individuals, premium assistance is not available

If you have a modified adjusted income exceeding $125,000

If you file a joint return, a modified adjusted income exceeding $250,000

Failure to report your ineligibility timely may result in excess reimbursements. Any ineligible payments can be treated as an underpayment of your payroll taxes and may be assessed and collected in the same manner as payroll taxes in accordance with Subchapter B of Chapter 65 of the Internal Revenue Code of 1986, SEC. 6432. COBRA PREMIUM ASSISTANCE.

If you fail to notify the EUTF when you become eligible forother group health plan coverage or Medicare AND continue to pay reduced COBRA premiums, you could be subject to a fine of 110% of the amount of the premium reduction (Subchapter B of Chapter 65 of the Internal Revenue Code of 1986, SEC. 6720C.)

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature:_____ Date:_____

Type or print your name:_____

NOTICE OF A COBRA-RELATED EVENT

Attn: Plan Administrator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the Plan Administrator of the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) of the occurrence of a qualifying event or other COBRA-related event. Notice is being provided in order to preserve the COBRA continuation coverage rights of the undersigned and all related qualified beneficiaries/covered dependents who are or were covered under the EUTF's group health plan(s).

The following COBRA-related event occurred on _____ :
[enter date in mm/dd/yyyy format]

☐ divorce of the covered employee and covered spouse

☐ legal separation of the covered employee and covered spouse

☐ a covered dependent child ceased to be a dependent under the terms of the EUTF's plan(s)

☐ a 2nd qualifying event occurred after a qualified beneficiary has become entitled to COBRA with a maximum coverage period of 18 or 29 months; the 2nd qualifying event was: _____
_____

☐ after electing COBRA, a qualified beneficiary became covered under another group health plan

☐ after electing COBRA, a qualified beneficiary became entitled to coverage under Medicare (Part A, Part B, or both)

☐ the Social Security Administration determined that a qualified beneficiary with a maximum COBRA coverage period of 18 months was totally disabled at any time during the first 60 days of COBRA coverage

☐ the Social Security Administration determined that a qualified beneficiary previously determined to be disabled is no longer disabled

The following individuals/qualified beneficiaries covered under the EUTF's plan(s) are affected by this event:

_____
_____
_____
_____

Documentation of the event including the date of its occurrence is attached. Please take the appropriate steps to enable the qualified beneficiaries affected by this event to exercise their COBRA continuation coverage rights.

_____ _____
Signature Date

_____ _____
Name of Covered Employee Telephone Number

_____ _____
Mailing Address City, State, Zip Code

Keep a copy of the completed form for your records.

Instructions for Completing the"Notice of a COBRA-Related Event"

The person completing this form should do the following:

1. Complete the form using blue or black ink. Do not use pencil. Write or print legibly.

2. Fill in the date that the event you are reporting occurred. Either show the date in full, for example, April 5, 2005 or use a month/day/year format, for example, 4/5/2005.

3. Check the box corresponding to the qualifying event or other COBRA-related event you are reporting. If none of the boxes apply, call the Plan Administrator at (808) 586-7390 for assistance.

4. List the names of all family members who (1) are or were covered under the Plan and (2) whose coverage under the Plan may be affected by the event you are reporting. Be sure to include your own name if it is appropriate.

5. Be sure to sign and date the form. Make a copy of the completed form and keep it in a safe place.

6. Indicate the name of the employee covered under the Plan. Show the employee's first name, middle initial and last name. Be sure to write or print legibly.

7. Indicate a current telephone number where the Plan Administrator may call you if there are any questions regarding your Notice.

8. Indicate the current mailing address where the Plan Administrator should send the COBRA Election Form or other correspondence. If you are reporting an event that affects the coverage of any family member who does not reside with you (for example, a child away at school), please note their current mailing address on the back of the form.

9. **Attach appropriate documentation to verify the date of the event you are reporting.** The "COBRA Notice" on the Plan's website provides examples of appropriate documentation for the different events. Call the Plan Administrator at (808) 586-7390 if you have any questions regarding the documentation you should provide.

10. Review the form to make sure it is complete. If you have any questions about completing the form, call the Plan Administrator at (808) 586-7390.

11. Return the completed form to the Plan Administrator at the address shown on the top of the Notice. You may return the Notice by mail, by fax, or you may deliver it by hand. You may fax the Notice to the Plan Administrator at (808) 586-2161. You may hand-deliver the Notice to the Plan Administrator at 201 Merchant Street, Suite 1520, Honolulu, HI.

12. If you mail the Notice, be sure to affix sufficient postage to the envelope. If the Postal Service returns your Notice because of insufficient postage, you may not be able to re-mail the notice in a timely manner. If your Notice is late, you will forfeit your rights under COBRA and you will not be entitled to elect or extend COBRA continuation coverage.

13. If you fax the Notice, be sure to keep a copy of the fax transmittal report showing the date and time the Notice was transmitted, the fax number that received the Notice and the status of the fax transmission.

CHANGE OF ADDRESS FORM

Attn: COBRA Coordinator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the COBRA Coordinator of the EUTF's group health plan(s) of a change in the mailing address of an employee, Qualified Beneficiary or other Plan Participant. The individuals identified below reside at the addresses shown below as of the date of this Form.

_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Signature of Employee	Date
_____	_____
Name of Employee	Social Security Number of Employee